MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
WIC AND NUTRITION SERVICES

WIC CERTIFICATION - WOMAN

AGENCY

☐ ADDITION ☐ RECERT

SCLR

DCN | LAST NAME | SUFFIX | FIRST | MIDDLE | MAIDEN

RACE
1 - WHITE 4 - AM. IND./ALASKAN 6 - NATIVE HAW/PAC ISL
2 - BLACK/AFRICAN AMER. 5 - ASIAN

ETHN HISP Y N U | BIRTHDATE | SOCIAL SECURITY NUMBER

COMMON DATA SYSTEM ID 02

H201 ADD H202 UPDATE

FAM. SIZE | FAMILY INCOME W M A $ | FIN. ELG. Y N A X | MARITAL STATUS (CIRCLE) S M W D SEP DECL | PRESENTLY EMPLOYED Y N U | TEMP MOHN T | FOOD STAMPS Y N U | FOSTER CARE Y N

STREET ADDRESS | CITY | STATE MO | ZIP CODE

PHONE ( ) | MESSAGE PHONE ( ) | PARTICIPANT EDUCATIONAL LEVEL | COUNTY OF RESIDENCE

HEALTH HISTORY

H204 ADD H205 UPDATE

LAST NML. MENSES DATE | PRIOR DEL. DATE | MO PRENATAL CARE BEGAN | PRE PREGNANCY HEIGHT /8 IN /10CM | PRE PREGNANCY WEIGHT LBS KG

GRAVIDITY | TERM | PRETERM | SPON ABORT | FETAL DEATH | CHILDREN LIVING (AT BIRTH)

SMOKING CHANGES DURING PREGNANCY? ☐

SMOKING/DRINKING BEHAVIOR 3 MONTHS PRIOR TO PREGNANCY
1. AVE # OF CIGARETTES SMOKED/DAY? ☐☐ 2. AVE # DAYS/WK HAD ALCOHOLIC DRINK? ☐☐
3. AVE # ALCOHOLIC DRINKS ON DAYS HAD A DRINK? ☐☐ 4. OTHERS IN HOUSEHOLD THAT SMOKE? Y N U

OUTCOME DATA ALL BREASTFEEDING & NON-BREASTFEEDING (DO NOT COMPLETE FOR PRENATAL)

H210 ADD H211 UPDATE

DELIVERY DATE | DELIVERY TYPE V C | PREG. WT. GAIN/LOSS IN LBS. + / – | (0-97) 98 (≥98) 99 (UNK) | FOOD STAMPS Y N U | OUTCOME IF: FD SA

DIABETES: Y N U | ONLY W/CURRENT PREGNANCY Y N | HIGH BLOOD PRESSURE Y N U | ONLY W/CURRENT PREGNANCY Y N

SMOKING CHANGES SINCE DELIVERY? ☐

SMOKING/DRINKING BEHAVIOR DURING LAST 3 MONTHS OF PREGNANCY
1. AVE # OF CIGARETTES SMOKED/DAY? ☐☐ 2. AVE # DAYS/WK HAD ALCOHOLIC DRINK? ☐☐
3. AVE # ALCOHOLIC DRINKS ON DAYS HAD A DRINK? ☐☐ 4. OTHERS IN HOUSEHOLD THAT SMOKE? Y N U

WIC ELIGIBILITY CLIENT DATA

CAPE SITE | PROG. P B N | MIGRANT M | SPECIAL STATUS H T O | CONTACT DATE | TYPE OF CONTACT T W

H402 RECERT H407 INQUIRY

SMOKING/DRINKING BEHAVIOR IN LAST 7 DAYS
1. AVE # OF CIGS SMOKED/DAY? ☐☐
2. AVE # DAYS/WK HAD ALCOHOLIC DRINK? ☐☐
3. AVE # ALCOHOLIC DRINKS ON DAYS HAD A DRINK? ☐☐

CURRENT SMOKE EXPOSURE
4. HOUSEHOLD SMOKING? Y N
5. SMOKING CIGARETTES, PIPES OR CIGARS? Y N

SEEING PHY. Y N | DIET ASSESS. Y N | EDC | PLAN BF Y N U

HEIGHT /8 IN /10CM | WEIGHT /4 LBS /10 KG | HLTH ASSESSMT DATE | HEMATOCRIT /10 | HEMOGLOBIN /10 | BLOODWORK DATE

H401 ADD H403 UPDATE

ORAL ASST. Y N | MED ELIG Y C M | RISK FACTORS | PRIORITY | FOOD PKG. | SEQ. | CYCLE 1 2 3

SERVICE DATE | RECERT. DATE | BMI | CPA INIT. | NEW FPC | NEW SEQ. | NEW CYCLE

REFER TO (CIRCLE): IMMUN SHCN | PHY SUB ABUSE | DNTL HLTH LEAD | TANF EXTEN | FD STAMPS COM BASED | MOHN OTHER | FAM PLN NO REFERRAL NEEDED | SCH HLTH

SIGNATURE (INCOME ASSESSMENT) | TITLE | DATE

SIGNATURE - (RISK ASSESSMENT) | TITLE | DATE

Delivery Date Mo. Yr.	Birth Weight Lbs. Oz.	Problems

DATE ID FOLDER GIVEN | DATE FOOD LIST GIVEN | WIC-30 CERT. PERIOD | WIC-30 LOCATION

I received the WIC Participant Identification Folder and the WIC Approved Food List on the dates listed above. I was advised on the specific requirements listed in both items. I certify the information and documentation I provided and was recorded on the WIC Proof of Eligibility Form (WIC-30) for my household is true to the best of my knowledge. If all documentation is not available at certification, I agree to furnish it within 30 days to remain on the program and receive benefits.
I have been advised of my rights and responsibilities under the WIC program. I certify that the information I have provided for my eligibility determination is correct, to the best of my knowledge. This certification is being made in connection with the receipt of federal funds. Program officials may verify information on this form. I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing or withholding facts may result in paying the state agency, in cash, the value of the food benefits improperly issued to me and may subject me to civil or criminal prosecution under the state and federal law.

PARTICIPANT/CAREGIVER SIGNATURE | DATE